Kansas Department of Health and Environment

Long Term Care Program

FACT SHEET II

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Fact Sheet II is published by the Kansas Department of Health and Environment and sent to all **assisted living, residential health care, adult day care and home plus facilities**. This newsletter provides important up-to-date information concerning the health care industry.

Revised Adult Care Home Regulations Effective October 8, 1999

Revisions of the Adult Care Home Regulations will become effective October 8. All licensed adult care homes will receive a copy of the revised regulations. Each type of facility will have a regulation booklet which will contain the Adult Care Home statutes, the regulations applicable to all adult care homes, and the regulations specific to the type of facility. The regulations for all Adult Care Homes will be available on the KDHE web site. Additional copies will be available for purchase by contacting the bureau office. New regulations for Home Plus facilities and Adult Day Care facilities will become effective on October 8.

The following list includes changes in the regulations related to all Adult Care Homes. Spelling and format changes are not included.

28-39-144(a)(5). Deletes the nurse aide requirement for an activity director for individuals who do not meet the requirements found in subsections (1), (2), (3), or (4).

28-39-144(g). Revises the definition for ambulatory resident by deleting “ascending and descending stairs with the assistance of another person.

28-39-144(h). Adds a definition for “applicant.”

28-39-144(vv). Definition for physician amended.

28-39-144(ccc). Deletes the nurse aide requirement for a social service designee for individuals who do not meet the requirements found in subsections (1) and (2).

28-39-145a. The regulation replaces 28-39-145. Licensure. The licensure regulation was rewritten to improve clarity.

The following are amendments to the Assisted Living/Residential Health Care Facilities.

28-39-240(b)(4). Deletes the requirement that the administrator/operator be a full-time position.

28-39-240(c). Allows an administrator/operator to supervise more than one facility under specific conditions.

28-39-240(f). New subsection on staff treatment of residents. Requirements more specific for the prevention and reporting of abuse, neglect and exploitation of residents.

28-39-245(b)(2). Provides for adult day care services in an assisted living/residential health care facility.

28-39-245(b)(3). Provides for the provision of respite care in assisted living/residential health care facilities.

28-39-247(b)(4). Allows for a special care section or for a facility to limit their services to residents with special needs.

28-39-247. This section was extensively rewritten to increase the specificity related to administration of medications and the drug regimen review.

New regulations will be effective for Home Plus facilities and Adult Day Care facilities on October 8.

Neglect Task Force

During the summer months, a task force composed of adult care home administrators, directors of nursing and state agency staff worked on the development of an administrative practice guideline for the prevention and reporting of resident neglect. Members of the task force included Pam Chambers, Adm., IHS of Great Bend; Thomas Church, Adm., Catholic Care Center, Wichita; Sharrion Edwards, DON, Life Care Center of Wichita; Linda Fry, DON, Meadowlark Hills, Manhattan; Mary Gedrose, DON, Anderson County Hospital, LTCU; Mary Jane Kennedy, Complaint Program Coordinator, KDHE; Patricia Maben, Director, Long Term Care Program, KDHE; Marla Myers, Investigator, Medicaid Fraud Control Unit, Office of the Attorney General; and Chuck Nigro, Adm. Johnson County Nursing Center, Olathe.

The focus of the guideline was neglect. The principles identified in the guideline would also apply to the prevention and reporting of abuse and exploitation. The state regulations for the prevention and reporting of abuse, neglect and exploitation apply to all adult care homes. Therefore, it is strongly recommended that each assisted living/residential health care, home plus and adult day care facility review their current policies and procedures with the guideline. A copy of the guideline is attached to this copy of FACT SHEET II. A decision tree for reporting neglect was also developed and is included with the guideline.

At the request of the task force, the reporting form used for self investigation of incidents is being revised and will be available from the complaint office in the near future. The task force also requested that the bureau publish examples of actual incidents reported to the complaint line which met the definition of neglect. A list of those incidents is attached.

Flu and Pneumococcal Pneumonia Immunizations

October and November are the prime times for facilities to immunize residents against the flu and pneumococcal pneumonia. Staff are encouraged to maintain immunization records on all residents.

Residents in adult care homes are at a higher risk for flu and pneumonia than the general population. Please contact each resident's physician concerning orders for the appropriate immunizations. Regulations do not require immunization of employees or volunteers. However, many facilities have found that offering flu immunizations for employees and volunteers reduces the amount of sick leave and the number of residents contacting the flu.

Caregivers Employed by Residents

One of the most frequently asked questions from assisted living/residential health care facility and home plus staff concerns the use of "sitters" or "companions." It is not unusual for a resident to have received care from an unlicenced individual in the resident's home prior to admission to a health care facility. It is assumed that the unlicenced individual can continue to provide care.

The regulations for Assisted Living/Resident Health Care Facilities, Home Plus and Adult Day Care limit the individuals who can provide personal care. The limitations in the regulations are based on the Nurse Practice Act and the Attendant Care Act. Personal care can be provided by the following:

1. Facility's direct care staff (licensed nurses, nurse aides and medication aides);
2. staff of a home health agency (licensed nurses, home health aides);
3. staff of a hospice (licensed nurses, home health aides); and
4. family and friends gratuitously.

Residents and families may employ a companion. The companion cannot provide direct care. Direct care is defined in the regulations as the following activities:

1. Grooming;
2. eating;
3. toileting;
4. transferring; and
5. ambulation.

Companions may not administer medications or provide any treatments ordered by a physician. Individual residents may employ a licensed nurse (licensed practical nurse or registered nurse) to provide direct care, administer medications or perform treatments ordered by a physician.

Physician Orders

All medications and treatments administered in an adult care home must be ordered by a physician. Medication aides cannot implement verbal or written orders for medications and treatments. Facilities must have a system in place which ensures that all written and verbal orders for medications are managed by a licensed nurse. A licensed nurse may provide verbal directions to a medication aide through a phone call. Any directions provided by the licensed nurse should be documented in the resident's clinical record by the medication aide and the licensed nurse.

Health Occupations Credentialing Update

On July 1, 1998, compliance with KSA 39-970 and KSA 65-5117 became mandatory for all adult care homes and home health agencies licensed through the Kansas Department of Health and Environment. Both bills require criminal background checks on all non-registered or non-licensed employees or applicants.

Depending on the offense, convictions for certain crimes may prohibit individuals from employment either permanently or for five years following the completion of all sentencing requirements. Under certain circumstances, expungement may be available through the court where the conviction occurred.

Below is additional information taken from the Criminal Background Check Program State Fiscal Year 1999 Report (July 1, 1998 through June 30, 1999).

- The total number of criminal background check requests processed in fiscal year 1999 was 43,191.
- Out of that number, 7,944 individuals had some type of arrest or conviction data.
- 175 Notices of Employment Prohibition were issued on 157 individuals (these individuals are prohibited from working in a licensed adult care home or home health agency unless expungement or, for certain crimes, verification is provided that more than five years have elapsed since completing sentencing requirements).
- Processing time from receipt of the Criminal background check request to receipt of the background check request and Notice of Employment prohibition if required was 15 working days or less for 85 percent of the requests received during the first year of operation.

For additional information, visit the HOC web page at: www.kdhe.state.ks.us/hoc.

CERTIFIED NURSE AIDE CURRICULUM REVISION

A revised nurse aide curriculum has been approved by the department and has been prepared for distribution by the Kansas Competency Based Curriculum Center at Washburn University. You may purchase a copy of the revised curriculum from the Kansas Competency Based Curriculum Center, School of Applied Studies, Washburn University, 1700 S.W. College, Topeka, Kansas, 66621, (785) 231-1010, extension 1534.

The changeover date for using the revised nurse aide curriculum is October 15, 1999. The current curriculum will be used until that date. Any course which begins after October 15, 1999 must be taught using the revised curriculum.

Appreciation is expressed to the curriculum revision committee. The committee included Janet Klasing, RN, BSN, MSN; Deanne Lenhart, BA, MCP, LNHA; Leanna Meeks, RN, BSN; Gayla Messenger, RN; Vicki Meyer, RN, C; Pat Rupp, RN, BSN; and Carolyn Trow, RN, ASN. The committee and other revisors worked diligently to provide an appropriate curriculum for the nurse aide and to meet the needs of instructors who will teach the course. The department thanks them for their effort.

The revised curriculum contains updated materials on the following:

- Facts about aging
- Resident's rights (additional information)
- Legal aspects of working as a nurse aide (responsibility to report changes in condition, definition of abuse, neglect and exploitation, and how it is reported)
- Emphasis in promoting a restraint-free environment
- Infection control information (additional isolation information)
- Working with confused or withdrawn residents
- Depression in the elderly
- Residents at risk for elopement
- Pressure ulcers

New materials include a section on rehabilitative and restorative care and a section on specialized procedures. The unit on vital signs has been moved to Part 1 and the units on nutrition have been combined into one unit. The units on working in an adult care home have also been combined into one unit.

The curriculum continues to consist of a minimum of 90 hours: at least 45 didactic and 45 clinical. Part I consists of at least 20 didactic hours and 20 clinical hours. The skills checklist will continue to be completed by the conclusion of Part I. Part II consists of at least 25 didactic hours and 25 clinical hours.

The department is interested in your feedback. Please address questions or comments about the revised curriculum to Martha Ryan at 900 S.W. Jackson, Suite 1051S, Topeka, Kansas, 66612, (785) 296-0058.

Out of State CNAs - REMINDER!!

Out of state CNAs must be scheduled to take the Kansas certification test ***before*** he or she is eligible to be employed as a nurse aide trainee II. ***Performing a skills competency checklist does not meet the requirement.*** Please advise any prospective out-of-state certified nurse aides to contact HOC for the appropriate forms. The fee is $10. A letter is sent directly to the applicant advising him or her of the test date, time and location. This letter should be made available to the prospective employer to copy and retain in the applicant's employment record to assure regulatory compliance. Employers are not in compliance with regulations if this document is not available.

Resources for Better Care

Kansas Public Health and Environment Information Library Catalog

The Center for Health and Environmental Statistics, through Kansas State University's Community Health Library Services, has published the agency's 1999-2000 Kansas Public Health and Environment Information Library (KPHEIL) catalog. This catalog lists the 800 pamphlets and factsheet titles and the over 1,000 audiovisual titles maintained in KPHEIL to support the mission of Agency programs. Over 200 of the audiovisuals are from HealthQuest and deal with stress and other self-help personal health topics. All of these items are available to the citizens of Kansas. Most of the printed materials are non-copyrighted factsheets which can be freely copied. Audiovisuals are available for borrowing at no cost other than return postage.

The point of contact for KPHEIL service is Chris Ponte at KSU (cponte@oz.oznet.ksu.edu). In order to keep costs low, orders are accepted only via e-mail, US Mail, and FAX.

A limited number of hard copies of the catalog are available. The catalog can be accessed through the KDHE web site: **http:www.kdhe.state.ks.us/library/listing.html.** By using your browser you can search for specific key words and titles. Over 100 of the factsheet titles are available as PDF files which can be downloaded on specific health and environmental issues. **Http://www.kdhe.state.ks.us/health-info/**

Dealing with Physical Aggression in Caregiving: Physical and Non-Physical Interventions.

The above set of three videos were purchased for the KPHEIL by the Kansas Health Care Association for use by long term care facilities. The videos were used in the presentation by Carly Hellen in the elopement workshop co-sponsored by KHCA and KDHE in June. The three video program with an accompanying workbook was designed to assist staff in developing a comprehensive program to prevent episodes of physical aggression. In addition, specific physical responses to dangerous, aggressive behavior by patients are demonstrated. The responses are designed to protect both patients and caregivers.

Fact Sheet II is published by the Kansas Department of Health and Environment. Bill Graves, Governor, Clyde D. Graeber, Secretary, Bureau of Health Facility Regulation, 900 SW Jackson, Suite 1001, Landon State Office Building, Topeka, Kansas 66612-1220, (785) 296-1240

Administrative Practice Guideline for Adult Care Homes/Hospital Long Term Units

This guideline was developed as a cooperative effort between the Kansas Department of Health and Environment, the Attorney General's office for Medicaid Fraud and representatives from the long term care industry. Although the focus of the guideline is the prevention and reporting of neglect, the process would also apply to the prevention and reporting of abuse and exploitation of residents.

Definition of practice area:

Kansas definition of neglect: "Neglect" means the failure or omission of one's self, caretaker or another person to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness. (K.S.A. 39-1401(g))

Federal definition of neglect: "Neglect" means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. *State Operations Manual* page PP-51.

Kansas reporting requirements. K.S.A. 39-1402....(a) Any person who is licensed to practice any branch of the healing arts, a licensed psychologist, a licensed master level psychologist, a chief administrative officer of a medical care facility, an adult care home administrator or operator, a licensed social worker, a licensed professional nurse, a licensed practical nurse, a teacher, a bank trust officer, a guardian or a conservator who has **reasonable cause** to believe that a resident is being or has been abused, neglected or exploited, or is in a condition which is the result of such abuse, neglect or exploitation or is in need of protective services, shall report **immediately** such information or cause a report of such information to be made in any reasonable manner to the department of health and environment with respect to residents..... Reports shall be made during the normal working week days and hours of operation of such departments. Reports shall be made to law enforcement agencies during the time the departments are not open for business. Law enforcement agencies shall submit the report and appropriate information to the appropriate department on the first working day that such department is open for business.

(d) Notice of the requirements of this act and the department to which a report is to be made under this act shall be posted in a conspicuous place in every adult care home and medical care facility in this state.

(e) Any person required to report information or cause a report of information to be made under subsection (a) who knowingly fails to make such report or cause such report to be made shall be guilty of a class B misdemeanor.

Federal reporting requirements. 42 CFR 483.13(c)(2)The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and

misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency.

(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate correction must be taken.

Kansas Statue Related to Mistreatment of a Dependent Adult. KSA 21-3437. Mistreatment of a dependent adult. (a) Mistreatment of a dependent adult is knowingly and intentionally committing one or more of the following acts:

(1) Infliction of physical injury, unreasonable confinement or cruel punishment upon a dependent adult;

(2) taking unfair advantage of a dependent adult's physical or financial resources for another individual's personal or financial advantage by the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense by a caretaker or another person; or

(3) omitting or depriving treatment, goods or services by a caretaker or another person which are necessary to maintain physical or mental health of a dependent adult.

(b) No dependent adult is considered to be mistreated for the sole reason that such dependent adult relies upon or is being furnished treatment by spiritual means through prayer in lieu of medical treatment in accordance with the tenets and practices of a recognized church or religious denomination of which such dependent adult is a member or adherent.

(c) For purposes of this section: "Dependent adult" means an individual 18 years of age or older who is unable to protect their own interest. Such term shall include:

(1) Any resident of an adult care home including but not limited to those facilities defined by K.S.A. 39-923 and amendments thereto:

(2) any adult care for in a private residence;

(3) any individual kept, cared for, treated, boarded or other wise accommodated in a medical care facility;

(4) any individual with mental retardation or a developmental disability receiving services through a community mental retardation facility or residential facility licensed under K.S.A. 75-3307b and amendments thereto;

(5) any individual with a developmental disability receiving services provided by a community service provider as provided in the developmental disability reform act; or

(6) any individual kept, cared for, treated, boarded or otherwise accommodated in a state psychiatric hospital or state institution for the mentally retarded.

(d) Mistreatment of a dependent adult as defined in subsection (a)(1) is a severity level 6, person

felony. Mistreatment of a dependent adult as defined in subsection (a)(2) and (a)(3) is a class A person misdemeanor.

ADMINISTRATIVE PROTOCOLS

The administrator/operator of an adult care home and the individual responsible for administrative oversight of a long term care unit in a hospital is responsible for ensuring that effective policies and procedures are developed and consistently implemented to reduce the risk of resident neglect. The following are recommended components of an effective policy to prevent neglect of residents.

Preemployment

1. Obtain and record references on all employees before date of hire.
2. Include in application form a question as to whether the applicant has a previous conviction for a crime against a person.
3. Check nurse aide registry and registries of health care professionals . Health Occupations Credentialing phone number is 785-296-0446 and the website is www.kdhe.state.ks.us/hoc.
4. Use a structured interview system such as "Behavior Based Interviewing" which includes exploring how the individual responds to stressful situations.
5. Perform Kansas Bureau of Investigation (KBI) background checks prior to first day of employment is recommended. KSA 39-970(d) states that "an adult care homes may hire an applicant for employment on a conditional basis pending the results from the department of health and environment of a request for information under this subsection. Hospital based units may contact the Kansas Bureau of Investigation at 785-296-8270 for information on how to obtain background checks on employees. **NOTE**: Hospital long term care units are not required by state law to conduct KBI background checks on employees.
6. Access the Office of the Inspector General website to insure that a prospective employee is not excluded from employment in Medicare/Medicaid certified facility. The website is www.dhhs.gov/progorg/oig/cumsan/1999/index/htm. This site includes facilities, agencies, businesses, health care professionals and nurse aides who have been excluded from the Medicare/Medicaid program due to having committed a criminal offense related to neglect or abuse of patients in connection with the delivery of a health care item or service.
7. Obtain written permission from each prospective employee for written references from former employers. K.S.A. 44-119a(1997 Supp.) provides for immunity for employer's from liability and suit for disclosure of employment information. Information which can be requested includes date of employment, pay level, job description and duties and wage history. A former employer has civil immunity for providing written information contained in employee evaluations. The previous employer may disclose whether the employee was voluntarily or involuntarily released from service.

Orientation

1. Require that each employee read the facility's policies related to the prevention and reporting of

neglect of residents prior to having contact with residents.

2. Provide examples of neglect with specific information how such situations should be handled by staff.

3. Develop and administer a written/oral test on the essential points of the policy.

4. Perform drug screens prior to employment. This is not a regulatory requirement, however some facilities have found this procedure to be useful. In addition, some facilities perform random drug screens on a regular basis.

Policies and Procedures

1. Incorporate the Federal and state definitions into the facility's policy for prevention and reporting of neglect.

2. Emphasize that reporting incidents is everyone's responsibility.

3. Develop a specific chain of command so that employees know specifically to whom they are to report. Emphasize that the administrator/operator must be notified of any incidents which could be determined to be neglect.

4. Use a specific form for reporting neglect which is available to all employees.

5. Ensure that all employees who are required by the Kansas statute to report neglect are aware that it is a misdemeanor to fail to report.

5. Develop an anonymous reporting system which can be used by staff, residents and visitors such as a phone with voice mail. Some facilities have found a "Concern" form which can be placed in a locked box a useful tool for anonymous reporting.

6. Facility- Self Investigation Procedure

A. All incidents in which there is a reasonable cause to believe neglect may have occurred must be investigated.

B. As soon as investigation indicates there is reasonable cause to believe neglect has occurred or it is determined that neglect did occur, the incident must be reported to KDHE. If the incident occurs on a day the KDHE Complaint Line is not in operation, the administrator/operator may want to send a FAX to KDHE with the name of the facility, name of reporter, date and time and state that an neglect report needs to be made. Hospital based

long term care units must report all incidents of neglect to the hospitals risk management system.

C. Local law enforcement must be notified by facility staff when it is evident that a crime has been committed such as sexual assault, battery or death as a result of neglect. The policy should clearly state who has the authority to notify the local law enforcement agency.

D. A specific form should be developed and implemented to document a facility self-investigation of neglect.

1. What happened?

2. Where did it happen?

3. Who was present or first noted there was a problem?

   (a) Staff

   (b) Family member/visitor

   (c) Residents

Note: Do not discount reports from residents who may have cognitive impairment.

4. When did the incident happen?

5. Who was first notified of the incident?

6. Date and time Administrator notified and by whom.

7. Date and time the resident's physician and family were notified..

8. Date and time KDHE Complaint Program notified.

9. Date and time local law enforcement was notified.

E. Obtain written witness statements from staff or other individuals who witnessed the event. It is recommended that witness statements be notarized. Facilities may choose to develop their own forms or may use the witness statement form developed by KDHE.

F. In some instances it would be useful to reenact the incident to help staff and residents remember details of the incident.

G. At the conclusion of the investigation, the administrator or designee should write a report which includes:

1. Summary of findings from the investigation process.

2. Identification of alleged perpetrator(s), if any.

3. Efforts taken to protect residents during the investigation.

4. Conclusions as to whether neglect occurred and rationale for that conclusion.

5. The signature of the administrator/operator or designee and date the report was completed..

H. This report can be a valuable resource for the administrator/operator to share with surveyors in the event a complaint investigation is initiated.

Staff Training

1. Ongoing training on prevention and reporting of neglect must be conducted on a periodic basis. It is recommended that inservice training be provided after an incident has occurred and at least annually.

2. The Kansas Advocates for Better Care provides training for direct care staff in long term care facilities on the prevention of abuse, neglect and exploitation. Contact KABC at 785-842-3088 for information.

Examples of Incidents which were Found to be Neglect

The committee working on the neglect policy requested that examples of situations which were reported to the KDHE complaint system be published in the FACT SHEET. The following are examples of actual calls received by the KDHE complaint line concerning incidents of resident neglect.

1. Resident developed pressure ulcer while in facility which eventually required surgical repair. Resident was incontinent and appropriate skin care was not provided. Family was not notified about ulcer until day of surgery.

Resident was reported to have difficulty breathing. Three days later he was admitted to hospital for pneumonia. Family stated that resident was not appropriately assessed. Family had to insist that physician be notified.

- Resident fell out of wheelchair while being pushed by nurse aide. Wheelchair was not equipped with foot rests. Resident placed feet on floor and was propelled forward. Injuries included laceration to head and injury to right wrist which required physician intervention.

- Resident admitted to hospital with signs and symptoms of dehydration. Reporter stated that the resident had poor oral intake for over one week, poor skin turgor, and swollen dry cracked lips. Diagnosis at admission to hospital was sepsis, dehydration and malnutrition.

- Resident was new admission to facility. Medication orders were phoned to two different pharmacies. Medications were not delivered due to a holiday weekend. Resident clinically unstable. Several medications were not administered. Resident admitted to hospital the day after the holiday and died the next day.

- Resident fractured their pelvis after several falls in the facility. A special cushion was to be placed in the resident's wheel chair to prevent falls. Resident fell. Cushion was not in place and wheel chair was not locked.

- Staff left resident outside in an enclosed patio and she developed a sunburn which required treatment with silvadene. This was the second sunburn the resident experienced this year. Resident also had large bruise of unknown origin on right foot.

- Resident reported as being agitated. Facility called durable power of attorney for health care and requested permission to take her to the emergency room. Resident had a fecal impaction which took several days to resolve. Resident had a history of constipation.

- Resident admitted to the emergency room for a large bruise and swelling on the left side of chest. The area on the chest was the size of a foot ball. Resident stated that someone hit her. Resident

had a diagnosis of dementia.

- Nurse aide noticed resident was crying when she pushed away from the dining table. The resident stated she had spilled coffee in her lap. There were red areas on her thighs that developed blisters. Post treatment included insertion of a Foley catheter. Caller was concerned that staff were not monitoring this resident while eating.

- Resident was given the wrong medication. The indication for the medication given in error was to slow the heart rate. The resident had a clinical condition which resulted in a slow heart rate. Facility faxed information about the incident to the physician at 7:30 AM. The physician responded at 10:30 AM.

- Facility did not ensure that laboratory tests were performed to monitor coumadin dosage. Resident was hospitalized because of an unrelated change in condition. After laboratory work was completed, Vitamin K was administered. Night nurse had marked through resident's name on list for laboratory work.

- Resident often saturated with urine. Dressing changes not performed as ordered by physician. Not repositioned in good alignment with pillows. Roommate reports that position not changed. Resident will require surgery for pressure ulcers which developed during stay in facility.

- Resident was dropped to floor during a transfer by an aide from a staffing agency. Resident sustained fracture of humerus.

- Resident found on floor in her room. Sustained a 3 centimeter laceration on bridge of nose which required suturing. Wheelchair was turned over. First incident of this type.

- Resident fell shortly after admission. On medication which would affect her balance and decision making ability. Sustained a fractured hip. No witness to the fall. Second resident fell in her room and fractured hip. No witness. Both instances occurred
in the space of 7 days.

- Resident's plan of care indicated that a mechanical lift was to be used for transfers. Two nurse aides lifted resident, unable to complete transfer, lowered resident to the floor, then by grasping residents extremities listed resident in to a chair. Resident sustained bruising on arms and legs and a skin tear on right toe.

- Aide was walking resident to bathroom without a gait belt as required by care plan. While aide was opening bathroom door, resident fell backwards and hit head on dresser. Head wound required suturing.

- Resident attempted to get back into bed after going to the bathroom. He felt he was going to fall,

so sat himself on the floor. Resident checked his watch. It was 1:30 PM. The incident report stated that he was found at 4:30 AM.

- Resident was found tangled in the side rails at 6:15 when staff went in to provide care Resident was dead. Autopsy indicated large abrasion over left eye, cut at bridge of nose, and a deep indentation on her neck which matched the siderails.

- Resident is 100 years old. Nurse inappropriately applied a second Fentanyl patch after 24 hours rather than 72 hours as ordered by physician. Resident also received an injection of Demerol. Resident became unresponsive. Resident was reported to have had no food or fluids over the weekend. He was admitted to hospital with severe dehydration.

- Nurse administered an overdose of morphine due to a calculation error. Staff did not record efforts to monitor for symptoms of overdose.